

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-007745

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 236

Primary Registration District No. 5819

Registrar's No. 22

FILED MAR 6 1963

VS 300
Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Morgan</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Morgan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Gravois Mills</u>		Length of stay in 1b <u>15 yrs.</u>	c. CITY OR TOWN <u>Gravois Mills</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Gravois Mills</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Gravois Mills</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Neval</u> Last <u>McLeod</u>		4. DATE OF DEATH Month <u>February</u> Day <u>27</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 29 1907</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHRYSETER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARPENTRY</u>	11. BIRTHPLACE (City and state or country) <u>Clinton, Mo.</u>
13a. FATHER'S NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>Eunice McLeod</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		17. INFORMANT Address <u>200 Eunice McLeod Gravois Mills Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED IMMEDIATE CAUSE (a) <u>Obstructive Pulmonary Emphysema</u> DUE TO (b) <u>Tuberculosis Suspected?</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Bronchitis</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from <u>July 1960</u> to <u>Feb 27, 1963</u> and last saw him alive on <u>Feb 26, 1963</u> Death occurred at <u>3:20 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. Washburn M.D.</u>		22b. ADDRESS <u>Versailles, Mo.</u>	
22c. DATE SIGNED <u>3/2/63</u>		22d. LOCATION (City, town, or county) (State) _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-4-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Hill Cemetery</u>	
24. FUNERAL DIRECTOR <u>Scrivner-Stevenson</u>		25. DATE RECD. BY LOCAL REG. <u>3-2-63</u>	
ADDRESS <u>Versailles, Mo.</u>		26. REGISTRAR'S SIGNATURE <u>J. Washburn</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

MAR 8 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James R. Scrivner

Licensed Embalmer No. 4880

P. O. Address Thrsault, Mo.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.

If this body is not embalmed, fact should be so stated above.